PRINTED: 07/05/2011 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155637	A. BUILDING	00	COMPLETED 06/17/2011
		100007	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/11/2011
NAME OF	PROVIDER OR SUPPLIE	R		117TH AVE	
CHICAG	OLAND CHRISTIA	N VILLAGE		N POINT, IN46307	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	· ·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
F0000	REGGE/HORT OF	CESC IDENTIFIED IN ORWINION	1710	·	DATE
			F0000		
v .			F0000		
	This visit was fo	or a Post Survey Revisit			
		R completed on 4/20/11 to			
	the Recertificati	on and State Licensure			
	Survey complete	ed on 2/23/11.			
	This visit was in	conjunction with a Post			
	This visit was in conjunction with a Post Survey Revisit (PSR) to Complaint				
	· · · · · · · · · · · · · · · · · · ·	vestigated on 5/19/11.			
	Survey dates: Ju	une 14, 15, and 17, 2011			
	Facility number	: 001198			
	Provider number				
	AIM number:	100471000			
	Survey team:				
	Regina Sanders,	RN-TC			
	Marcia Mital, R	N			
	(June 15, 2011)				
	Sheila Sizemore	e, RN			
	(June 15, 2011)				
	Kelly Sizemore,				
	(June 15 and 17,	, 2011)			
	Census bed type	: :			
	SNF: 26				
	SNF/NF: 106				
	Residential: 39				
	Total: 171				[

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OVPC13

Facility ID:

001198

TITLE

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MU A. BUIL B. WING	DING	00	(X3) DATE S COMPL 06/17/20	ETED
	ROVIDER OR SUPPLIER		•	6685 E 1	DDRESS, CITY, STATE, ZIP CODE 117TH AVE I POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0282 SS=E	Cited in accordant Quality review of 2011 by Bev Fau The services provifacility must be provin accordance with plan of care. Based on observatinterview, the fact physicians' order care were follow administration, signal interventions reviewed for foll care and physicians.	es reflect state findings ce with 410 IAC 16.2. completed on June 20, lkner, RN ded or arranged by the ovided by qualified persons a each resident's written ation, record review, and cility failed to ensure and residents' plans of ed related to medication kin tear interventions, and for 5 of 14 residents owing residents' plans of ans' orders in a total dents (Residents #B, #C,	F02	282	Event ID#OVPC13 6/27/11 for 0282 What is the corrective action taken for the resident found to be affected by the deficient practice? 1. Reside #C's MD was called 6/14/11 clarify aricept order. The ord was clarified to continue with Aricept 5 mg po qHS times for weeks and then increase dos 10 mg po QHS for diagnosis cognitive disorder.2. Reside #D's physician was notified 6/15/11 regarding condition of skin tear. Bactroban was discontinued and area open air.3. Resident #B order for Bacitracin to right gluteal	ent to ler our se to of nt	06/27/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OVPC13 Facility ID:

001198

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155637	B. WIN			06/17/2	011
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			l	117TH AVE		
CHICAC	OLAND CHRISTIAN	LVILLAGE			N POINT, IN46307		
CHICAG	OLAND CHRISTIAN	VILLAGE		CROW	N FOINT, IN40307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1. Resident #C's	record was reviewed on			area was updated by physici		
	06/14/11 at 2:35 p.m. The resident's				6/15/11 to discontinue Bacitr		
		ed, but was not limited to,			to right gluteal area leave op	en to	
	dementia.	,			air. 4. Resident #E's physician was notified 6/17/1	11	
					and order was clarified to	. I	
					Voltaren apply 2 GM to each	hand	
		ler, dated 05/25/11,			BID due to pain.5a. Resider		
		er for Aricept (cognition			care plan was updated 6/15/		
	medication) 5 mg	g (milligrams) at bedtime			resident to have nurse alarm	⊦in	
	for 30 days then	increase the Aricept to 10			bed 5b. Resident #F a note		
	mg at bedtime.				written 6/17/11 in nurses not		
					that she is encouraged to we		
	A Medication Ad	lministration Record			geri sleeves and will wear for short period of time and rem		
		/11, indicated the			6/20/11 note in nurses note s		
					resident now refusing to have		
		the Aricept 5 mg at			sleeves applied. Physician of	-	
	bedtime on May	26-31, 2011.			6/20/11 to discontinue geri		
					sleeves.How will other reside	ents	
	There was a lack	of documentation on the			having the potential to be aff		
	MAR, dated 06/1	1, to indicate the resident			by the same deficient practic		
	had an order for	Aricept 5 mg at bedtime.			identified and what corrective		
		of documentation on the			action will be taken? All resi have the potential to be affect		
		1, to indicate the resident			by this deficient practice. W		
	-				house audit was conducted of		
		ept as ordered by the			6/17/11 of all resident		
	physician.				records.What measures will	be	
					put into place or what systen		
	During an observ	vation of the Aricept			changes will be made to ens		
	medication card	on 06/14/11 at 3:20 p.m.,			that the deficient practice do	es	
	with LPN #3 pre	sent, the medication card			not recur?The nurse		
	-	peen delivered by the			management team will be tra on how to complete the end		
	pharmacy on 05/25/11 and 30 tablets of				month physician order, MAR		
					TAR review process. Only tr		
	Aricept had been delivered. The Aricept				personnel will be allowed to		
	medication card indicated there were 15		complete this monthly process.				
	tablets left in the card. (there should have				All licensed staff working the		
	been 20 tablets u	sed if given every night).			shift will be educated on the		
					nightly 24-hour physician ord	ler	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155637	B. WIN			06/17/2	011
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R		1	117TH AVE		
CHICAG	OLAND CHRISTIAI	N VII I AGE		1	N POINT, IN46307		
					N 1 OIN 1, IN 40007		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG			DATE
	_	riew on 06/14/11 at 3:20			chart review guideline proces		
	p.m., LPN #3 in	dicated the Aricept order			This process includes verifyi that all new physician orders		
	was not on the M	AAR. She indicated the			the previous 24 hours have the		
	Aricept had not	been given as ordered.			placed on the Medication	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	1				Administration Records and	on	
	2 Resident #D's	s record was reviewed on			the Treatment Administration	1	
		5 a.m. The resident's			Records as indicated. All		
					licensed staff will be educate		
	_	ed, but was not limited to,			transfer order clarification an		
	dementia.				also the month end process		
					all new medication or treatments orders received after the	eni	
	A Physician's or	der, 05/25/11, indicated			Physician Order Sheets have	۵ .	
	an order for Bac	troban (antimicrobial			been signed as reviewed thre		
	cream) to the res	sident's left shin wound			the end of month process ha	~	
	daily until heale				been transcribed to both the		
		u.			current month's MAR and/or	TAR	
	The TAD (Toronto	or and Administration			and the upcoming month's M		
	`	ment Administration			and/or TAR. Nurse Manage		
	, · ·	5/11, indicated the			perform a double check of the		
	Bactroban treatn	nent had been completed			each day during their clinical review process beginning on		
	daily on May 25	-30, 2011. The TAR			23rd of each month through		
	indicated the Ba	ctroban treatment had not			last day of the month to assu		
	been completed	on 05/31/11 due to the			compliance. All resident care		
	_	ut of the building.			plans have been reviewed a	nd	
					updated per resident		
	There was a leaf	of documentation on the			assessment. A process has	been	
					established to communicate	h o	
	· ·	1, to indicate the resident			resident care plan needs to t CNA's on a daily basis. Nurs		
		the Bactroban treatment.			staff will receive both directe		
		of documentation on the			education and facility provide		
	TAR, dated 06/11, to indicate the				education on following		
	Bactroban treatment had been completed				individualized resident care p	olans	
	as ordered by the physician.				and physician orders. What		
	as or across by the projection.				corrective action(s) will be		
	There was a lack of documentation in the		monitored to ensure the deficient				
					practice will not recur, i.e., w		
	I -	eian's Orders and the			quality assurance program w	ılı be	
	Nurses' Notes, d	ated 05/25/11 to 06/15/11,			put into place? Director of		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155637	B. WIN			06/17/2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	ļ
NAME OF F	PROVIDER OR SUPPLIER	1		1	117TH AVE	
CHICAC	OLAND CHRISTIAN	IVIIIACE		1	N POINT, IN46307	
	OLAND CHRISTIAN	VILLAGE		CROW	N FOINT, IN46307	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	to indicate the resident's left shin wound				Nursing and Administrator w	ill
	had healed or tha	at the Bactroban had been			monitor compliance through	
	discontinued.				random weekly audits includ	
	discontinued.				physician order and MAR/TA	AR
	Duning on chaom	ration of the maridantle			comparison and care plan intervention implementation	for 3
	•	vation of the resident's			months and report findings to	
		with RN #4 on 06/15/11			QA committee. The facility's	
	_	e resident had a scabbed			internal QA team has been	
	area on the left s	hin. The resident's wife			provided a tool that will be	
	was present duri	ng the observation and			updated with each change ir	
	indicated the stat	ff were no longer putting			resident's plan of care to fac	l l
	a treatment on th	e resident's shin.			daily monitoring of care plan	
					approach implementation. D	
	Di	: 06/15/11 -+ 1.15			rounds will be conducted util this tool to assist with monito	- I
	_	iew on 06/15/11 at 1:15			and continued compliance.	ning
	* ·	cated the wound was not			and continued compliance.	
	healed.					
	3. Resident #B's	record was reviewed on				
	06/15/11 at 10:5:	5 a.m. The resident's				
		ed, but was not limited to,				
	anemia.	ed, out was not immed to,				
	ancina.					
	· ·	der, dated 05/17/11,				
	indicated an orde	er for Bacitracin				
	(antibiotic ointm	ent) daily to the resident's				
	right gluteal (but	tock) open area.				
		•				
	The TAR dated	05/11, indicated the				
	· ·					
	Bacitracin treatment had been completed as ordered 05/17/11 through 05/24/11. The TAR indicated the Bacitracin treatment had been discontinued on 05/24/11.					
	There was a lack	of documentation in the				
	1 11010 Was a lack	or documentation in the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			Ì		INSTRUCTION 00	(X3) DATE S COMPL	
		155637	A. BUII B. WIN			06/17/2	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CHICAG	OLAND CHRISTIAN	I VII I AGE		1	117TH AVE N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	V1 OIIV1, IIV+0007		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	^ *	s, dated 05/17/11 through					
		cate the physician had					
	discontinued the Bacitracin treatment. The resident's TAR, dated 06/11, indicated						
		pleted the Bacitracin					
	treatment on 06/0	01/11 through 06/14/11.					
	.	0.6/1.5/11 11					
	_	iew on 06/15/11 at 11 cated she was unsure why					
	the Bacitracin tre						
	discontinued on 05/24/11.						
	During an intervi	iew on 06/15/11 at 11:10					
	· ·	licated she was using the					
		resident's right gluteal					
	area.	ecord was reviewed on					
		a.m. Resident E's					
		ed, but were not limited					
		art failure, osteoarthritis,					
	and osteomyelitis	S.					
		oital discharge orders,					
	· ·	icated to continue					
	,	cation for arthritis) gel wice a day to bilateral					
	hands.	wice a day to offateral					
	The resident's ad	mission physician's					
	•	/11, indicated the					
		to be applied to the					
		twice a day as needed for					
	pain.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637		A. BUII	LDING	NSTRUCTION 00	(X3) DATE : COMPL 06/17/2	ETED	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8		1	117TH AVE		
	OLAND CHRISTIAN			1	N POINT, IN46307		
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	Record), dated 5 Voltaren was to l twice daily to the	ication Administration /11, indicated the pe applied as needed resident's hands and had stered at all for the month					
	the Voltaren gelday on 6/1/11 at MAR then indicated to be applied to the needed. This was discontinued. The further document resident's TAR (*)	AR, dated 6/11, indicated was administered twice a 6 a.m. and 6 p.m. The ated "rewritten 6/1/11." Indicated the Voltaren was the resident's hands as also yellowed out as here was a lack of any tation on the MAR or the Treatment Administration foltaren being applied to inds.					
	p.m., RN #1 indidischarge orders followed. She in orders take precent through the order physician. She is should have been She indicated shorder had been defor June. 5. Resident F's resident condensated in the physician order had been defor June.	iew on 6/15/11 at 12:55 cated the hospital should have been dicated the hospital edence and the nurse goes rs with the resident's ndicated the Voltaren n applied twice a day. e did not know why the iscontinued on the MAR ecord was reviewed on a.m. Resident F's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/17/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	1 ~	ed, but were not limited ia, anxiety, and stroke.					
	assessment,dated Resident F was n decision making. assessment indica	6 (Minimum Data Set) 05/03/11, indicated noderately impaired in The quarterly MDS ated Resident F required nce of one staff for					
	5/30/11, indicated risk for falls, sco	assessment, dated d the resident was a high ring 16, a score of 10 or resident at risk for falls.					
	documentation of bed alarm. The f	alls, dated 2/14/11, lacked f a fall intervention for a fall intervention added on lacked with the reducate staff on lalarm."					
	dated 5/30/11, incobserved sitting of near doorway @ interview resident bed 15 min (minulow bed et (and) crawled out as sh	nent Program Note," dicated "Resident was on her room (sic) floor (at) 9:15 a.m. Per staff at had been assisted to ates) prior. She had a is believed to have he stated 'just wanted to at has no injury. She was					
	assisted to w/c (v re-educate staff o alarmPlan of a						

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155637		LDING	00	06/17/2	
		100007	B. WIN		DDDEGG CITY GTATE ZID CODE	00/11/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		1	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		-educate staff on proper		IAU			DATE
	use of bed alarm'						
	An observation o	on 6/15/11 at 9:50 a.m.,					
		nt F had a bed alarm on					
	her bed.						
	During an intervi	iew on 6/15/11 at 10:58					
		cated "According to the					
	report the resider	nt did not have the alarm					
	turned on." RN #	#4 indicated the CNAs					
	are supposed to c	check the alarms to make					
	sure the alarms a	re working.					
	B) Resident F w	as observed on 6/15/11 at					
	9:50 a.m. and 10	:20 a.m., the resident was					
	up in her wheelcl	hair and did not have on					
	her geri sleeves.						
	A physician's tele	ephone order, dated					
	6/9/11 at 9:00 p.r	m., indicated "Monitor					
	· ·	ght) upper (arrow					
	1	s) arm every shift until					
		eves as tolerated d/t (due					
	to) fragile skin."						
	During an intervi	iew on 6/15/11 at 10:20					
	a.m., CNA #5 in	dicated the resident					
	should have had	on her geri sleeves.					
	CNA #5 was obs	erved on 6/15/11,					
	applying Resider	nt F's geri sleeves at 10:25					
	a.m. Resident F	allowed the CNA to					
	apply the geri sle	eves without problem.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/17/2011				
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		

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If continuation sheet

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	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/17/2011	
	ROVIDER OR SUPPLIER			6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
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F0323 SS=D	environment rema hazards as is poss	nsure that the resident ins as free of accident sible; and each resident supervision and assistance accidents.	F0	323	Event ID#OVPC13 6/27/11 Chicagoland Christian Villag continues to ensure that the resident environment remain free of accident hazards as it possible; and each resident receives adequate supervisitiand assistance devices to produce the deficient. What is the correct action taken for the resident found to be affected by the deficient practice? Resident fall care plan has been revier for accuracy and was update 6/15/11 for resident to have alarm in bed. How will other residents having the potential be affected by the same define practice be identified and which corrective action will be take All residents assessed as beat risk for falls have the potential beaffected by this deficie practice. Whole house audit conducted on 6/17/11 of all resident records. What meas will be put into place or what systemic changes will be made ensure that the deficient pradoes not recur? All resident for care plans and CNA care guithave been reviewed and upon per resident assessment. A process has been established communicate resident care pneeds and changes to the Connadard pages and changes to the Connadard pages. Nursing states.	e e e s as as s s on revent tive : F's wed ed an el to icient ent ent et was ures ed to ctice fall ide dated ed to olan NA's	06/28/2011

001198

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		A. BUILDING	E CONSTRUCTION 00	· 	(X3) DATE SURVEY COMPLETED 06/17/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307					
	Based on observatinterview, the factinterventions were to prevent further	ATTEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) attion, record review and cility failed to ensure fall re in place and working re falls from occurring for with falls in a sample of	668	receive to and facility following care plar What commonitore practice quality as put into put		ion on on ent lers. I be cient hat vill be ill ing and ernal a each of ring	(X5) COMPLETION DATE	
	An observation o	on 6/15/11 at 9:50 a.m., on F had a bed alarm on						

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NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			ST 66	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		II PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	6/15/11 at 10:09 diagnoses includ	ord was reviewed on a.m. Resident F's ed, but were not limited ia, anxiety, and stroke.						
	assessment, dated Resident F was n decision making. assessment indic	6 (Minimum Data Set) d 05/03/11, indicated noderately impaired in The quarterly MDS ated Resident F required nce of one staff for						
	indicated the resi falls, scoring 16,	dent was a high risk for a score of 10 or higher at risk for falls.						
	documentation o bed alarm. The f	alls, dated 2/14/11, lacked f a fall intervention for a fall intervention added on l "Re-educate staff on l alarm."						
	dated 5/30/11, in observed sitting of near doorway @ interview resider bed 15 min (min low bed et (and) crawled out as shiget out.' Resider	nent Program Note," dicated "Resident was on her room (sic) floor (at) 9:15 a.m. Per staff at had been assisted to attes) prior. She had a is believed to have the stated 'just wanted to at has no injury. She was wheelchair). We will						

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	re-educate staff of alarmPlan of a	on proper use of action to prevent e-educate staff on proper		IAG			BILL	
	An undated CNA Care Record, indicated bed alarm was not marked.							
	An undated C-hall report sheet, indicated a lack of documentation of a bed alarm for the resident.							
	During an interview on 6/15/11 at 10:58 a.m., RN #4 indicated "According to the report, the resident did not have the alarm turned on." RN #4 indicated the CNAs are supposed to check the alarms to make sure the alarms are working. RN #4 indicated the bed alarm should have been checked on the CNA Care Record.							
	"Fall Prevention" policy of Christic each resident with assessment and i	dated 4/3/10 and titled 'indicated "It is the an Homes, Inc. to provide the an appropriate an appropriate anterventions to prevent mize complications if a						
	04/20/11. The fa	was cited on 02/23/11 and cility failed to implement of correction to prevent						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/17/2011		
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307					
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F0328 SS=D	proper treatment as special services: Injections; Parenteral and enterior Colostomy, ureter Tracheostomy care; Tracheal suctionin Respiratory care; Foot care; and Prostheses. Based on record facility failed to dispection cap chawere completed of (Peripherally Inseline for 1 of 2 resin a sample of 14 Findings include Resident E's record facility failed to dispect for 1 of 2 resin a sample of 14 Findings include Resident E's record facility failed to dispect for 1 of 2 resident E's record facility failed to dispect for 1 of 2 resident E's record facility failed to dispect for 1 of 2 resident E's record facility failed to dispect for 1 of 2 resident E's record facility failed fac	review and interview, the ensure dressing changes, nges and measurements weekly on a PICC erted Central Catheter) ident's with PICC lines . (Resident E)	F032	28	Event ID#OVPC13 6/27/11 F 328 Chicagoland Christian Village continues to ensure that resists receive proper treatment at care for the following special serves:Parental and enterafluids What is the corrective action taken for the resident found that affected by the deficient practice? Resident E's PICC line was discontinued on 6/5/11, medications were continued	dent' nd al o be	06/28/2011	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		I DDIG	00	COMPL	ETED	
		155637	1	LDING		06/17/2	011	
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
0111040	OLAND OLIDIOTIA			6685 E 117TH AVE				
CHICAG	OLAND CHRISTIA	N VILLAGE		CROW	N POINT, IN46307			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					ordered through a periphera	ıl line.		
	A nurses' note, d	lated 5/12/11 at 6 a.m.,						
	indicated "Resid				How will other residents have			
	1	•			the potential to be affected by	by the		
	1 ' ' '	intravenous) Zosyn to R			same deficient practice be	_		
	1 ` • ′	used S (without)			identified and what corrective action will be taken? All cur			
	difficultydrsg	(dressing) D/I (dry and			residents with PICC lines ha			
	intact)"				the potential to be affected by			
	1				deficient practice. What	. y		
	A TAR (Treatme	ent Administration			measures will be put into pla	ace or		
	`	/01, (RN #1 indicated			what systemic changes will			
	1 ''				made to ensure that the def			
	1	n dated 5/11, on 6/15/11			practice does not recur?All			
	1 //	ndicated the PICC line			resident with PICC lines with	n have		
	dressing change	, injection cap change,			their medical records review			
	and the external	length of the PICC line			All deficient practice identifie			
	were to be done	every 7 days and as			be immediately corrected. I	Each		
	1	R indicated the dressing			PICC line will receive a			
		•			documented dressing chang each week which includes	j e		
	1	n cap, and measurement			injection cap changing and			
	1 ^	on 5/12/11. There was a			external length PICC line			
	lack of documer	ntation to indicate the			measurement. Nurse			
	dressing change	, injection cap change,			Management has received			
	and measuremen	nt had been completed			directed education regarding	9		
	after 5/12/11.	-			weekly PICC line document	ation		
					compliance.			
	The TAD detail	6/11 looked			What corrective action(s) w			
	The TAR, dated				monitored to ensure the def			
		o indicate the PICC line			practice will not recur, i.e., v			
	dressing changes or the measurements of				quality assurance program very put into place?	will DE		
	the external PIC	C weekly.			Director of Nursing and			
	The nurses' notes, dated 5/13/11 through 6/4/11, lacked documentation of the PICC				Administrator will review we	eklv		
					PICC line documentation for	-		
					compliance ongoing. Direct			
	1	d injection cap being			Nursing and Administrator w			
	1				monitor compliance through			
	1	neasurements of the			random weekly audits includ	-		
	external length of	of the PICC line.			review of PICC line dressing	•		
					documentation for 3 months	and		

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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIE	DATE	
	indicated "Called PICC line laying res(resident). Co & measures 43 c R upper arm who s (without) any b trauma or infecti after the dressing. During an interv p.m., RN #1 indivingection cap had had the external weekly. An undated facil Line or Medline Change", received via e-mail, on 6/indicated "Free hours the frequent and PRN (as need for swelling, red all dressing channel length of the cather migration (move occurred. Period placement, tip losecurity of dress the catheter exit swabstick starting.	mplete PICC line intact m (centimeters). Site to be pre PICC line removed is bleeding, no signs of on" This was 24 days g had last been changed. Siew on 6/15/11 at 12:25 cated the dressing and last been changed nor PICC line been measured Sity policy, titled "PICC Catheter Dressing ed from the Administrator 15/11 at 7:57 p.m., quencyAfter the first 24 may is every seven days ded)Inspect the exit site mess, exudates. During ges assess the external meter to determine if ment) of the catheter has dically confirm catheter cation, patency, and ingUsing friction clean			report findings to the QA committee.			
	changedApply	transparent dressing"						

001198

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		155637	A. BUII	X2) MULTIPLE CONSTRUCTION A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE		(X3) DATE SURVEY COMPLETED 06/17/2011	
CHICAGOLAND CHRISTIAN VILLAGE			CROWN POINT, IN46307				
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R0000	3.1-47(a)(2)						
			RO	0000			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OVPC13 Facility ID:

ty ID: 001198

If continuation sheet

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